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Bringing the Outside In: Clinical Psychology Training in Socially Aware Assessment, Formulation, Intervention, and Service Structure

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We describe the introduction of the Power Threat Meaning Framework to our teaching on critical and community psychology with particular reference to formulation, and critically consider the implementation of this teaching.

The University of Edinburgh/NHS Scotland clinical psychology academic curriculum is organized according to overarching teaching themes that relate to the development of core competencies in assessment, formulation, intervention, and research, alongside professionalism and practice. Core teaching time is also dedicated to what we call the ‘fundamentals’ of clinical psychology, which considers the philosophical underpinnings of the profession. We believe this facilitates the adoption of a critical evaluative stance which informs contemporaneous psychological practice which is sensitive to health and social care exigencies. As part of this broader theme, and in line with BPS (2014) standards, we also ensure that trainees have an awareness of the cultural, historical and social context of their work, and an understanding of social approaches to intervention.

In practice, this has involved a stream of teaching which is dedicated to community, critical and social constructionist perspectives, first developed in its current format in 2012. The principal objectives are to encourage trainees to develop an awareness of social inequalities and their impact; to introduce basic concepts from critical psychology and social constructionism; to consider how these ideas may influence the ways in which we as professionals operate; and to debate where such ideas and their impact leave clinical psychology as a profession. This comes with a health warning that some of the challenges raised by a critical psychology stance may be experienced as uncomfortable. We are

therefore keen that the sessions don't simply become a talking shop, but are linked to formulation and specific kinds of interventions and/or service structures. In 2018, we introduced the Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018a) during second year, suggesting that it can be seen, among other things, as a theory driven formulation framework that attempts to directly address critical psychology's concerns about the potential neglect of the social context. We emphasise that the PTM Framework, like any other approach to formulation, requires evaluation.

Workshop structure and content

Didactic teaching in relation to critical psychology is kept to a minimum. Instead we utilise experiential tasks, small group and whole cohort discussions to explore key concepts. For example, one of the first tasks is to ask trainees to reflect on problems of engagement. This discussion typically begins by locating engagement difficulties and attrition within individual client characteristics, but very quickly shifts to a consideration of the contribution of the broader service and social context in which people seek help. This is followed by a discussion about the impact of inequality on a broad range of health and social outcomes. Using Scottish data always provokes lively debate. For example, Scotland is one of the West's most unequal societies with the wealthiest households 273 times richer than the poorest (Oxfam, 2013). Furthermore, 31% of women workers in Scotland are low paid, and all identified ethnic minority groups have higher than average rates of poverty (Oxfam, 2011). Such data is used to illustrate how inequality may be an actual material difference or a socially constructed one that differentiates using categories such as gender and race.

The Scottish government is explicit about its intentions to address the impact of inequality and childhood adversity on numerous health and social outcomes (Scottish Government, 2016). For example, the National Trauma Training Framework (NES, 2017) supports all workers to adapt their practice to make a positive difference to people affected by trauma and adversity. What we try to foster in our workshops is an understanding of how inequality not only involves exposure to material risks such as damp housing and poor diet but also to psychological risks such as feeling unsafe or socially excluded. It is the psychological risks that have particular relevance from a mental health perspective (Friedli, 2009). Thus, feeling unsafe, isolated and lacking control over key aspects of life as well as having reduced expectations can lead to feeling humiliated or ashamed, afraid or

mistrustful, lonely, trapped and powerless. In the workshops, we explore the notion that these reactions along with their behavioural expressions may reflect more or less adaptive responses to specific social contexts.

Subsequently, trainees are introduced to key concepts from critical psychology and social constructionism. For example, we encourage trainees to consider how historico-socio-cultural variables may influence the development of specific constructs. To illustrate, we ask them to discuss the impact of creating diagnostic categories on both the individual who might ultimately receive that diagnosis and on the clinician who bestows it. Initially, we use the example of 'drapetomania' (see <https://en.wikipedia.org/wiki/Drapetomania>) but then ask trainees to consider differential responses to, for example, conceptualizing someone as highly shy versus socially phobic. This exercise is intended to introduce trainees to the 'archaeological methods' proposed by Foucault (1969).

Key to this exercise is that trainees are then asked to apply the same level of critical analysis to the construct 'psychological distress'. Typically, they report finding it thought-provoking and challenging even to reach consensus about how to define 'psychological distress'. By focusing in on the origins of the distress, we encourage trainees to develop a clarity about what it really is that people find helpful (Diamond, 2006), and to be able to articulate this understanding clearly. They are further encouraged to explore the values (e.g. those related to gender and race) frequently implicit in mental health narratives through various discourse analysis tasks (e.g. of a newspaper article discussing pertinent issues relating to mental health). Boyle's (2003) deconstruction of vulnerability is used as a key text to open up discussions about the operation of language and power, allowing trainees to examine how some modes of psychological experience are given privileged status above others (Parker, 1999).

Beyond awareness-raising, the workshops are designed to encourage exploration of how adopting a critical psychology stance may – or may not - require different ways of responding to clinical scenarios. Following Smail (2006), we wonder whether 'clients find a realistic assessment of their options – one that take account of limits imposed on their freedom of action both by social environment and their nature as physical beings - more reassuring than threatening'. In this context, the PTM Framework was introduced as a more socially aware perspective from which to formulate and create narratives, one that provides

a comprehensive psychological understanding of distress that can be held up as a theory driven alternative system to diagnostic approaches.

Trainees are asked to familiarize themselves at least with the 2 page PTMF summary before the session but are also encouraged to have a look at the PTM Overview (Johnstone & Boyle, 2018b). We suggest that the PTMF encourages an explanation of distress consistent with a lifespan approach that takes account of proximal and more distal risk factors as well as variables that promote resilience. Without any requirement to share personal details, trainees are also encouraged to consider their own life circumstances using the Framework template to think about what's happened to them (power), how this power has impacted on them (threat) and how they have made sense of this (meaning). If this is not comfortable then they are asked to think about somebody whose life narrative they know well. They are also asked to consider what social discourses may be relevant to this understanding, and to contemplate the strengths and resources they may have been able to draw on to make changes, if required.

The exercise is then repeated using prepared case material. For example, trainees may be asked to consider the impact of sexual assault on a young woman in her early twenties. This allows a consideration of individual differences in response to that assault that includes not only aspects such as memory processing, but also the differential impact of power within a given social context. The need to retain a focus on the embodied nature of distress is emphasised. For example, the individual may require help managing intrusions such as flashbacks, for which the clinician should draw on the best available evidence to inform their intervention. However, the explicit focus of the Framework on the negative operation of power moves beyond this embodiment to consider, for example, how legal power or the accumulation of social capital may influence the young woman's understanding of what's happened to her and how she may respond. The core threats are thus understood within this kind of formulation not only to be bodily and emotional in nature, but to impact at the level of the relational, the social /community and the economic. The meaning given to the assault is deeply personal, but this is influenced by prevailing socio-cultural discourses and ideologies. Threat responses are understood within these contexts as attempts to cope with the impact of the assault, rather than as 'symptoms'.

Formulating case material in this way is followed by wide-ranging discussions about the kinds of intervention they inform, what outcomes are helpful and how they may be evaluated. Importantly, trainees are also asked to consider whether these kinds of formulations differ from more standard practice. For example, to what degree should the focus of intervention be 'symptomatic' or distress reduction? If distress arises as an embodied response to life circumstance, to what extent should therapeutic intervention rather focus on empowering the individual to bring about a change in their environment in order to benefit from materially less risk? One trainee commented that they found a 'marbles on a wobbly table' analogy useful; that is, how long do you keep trying to juggle the table to keep the marble from falling, before actually addressing the stability of the table itself. But what kinds of intervention would be involved in this shift of focus? In this example, ensuring the young woman has the psychosocial resources to be able to attend, for example, a self-defence course may be important. This might involve addressing barriers to attendance, such as flashbacks, low mood and/or anxiety as well as structural barriers such as lack of money, transport or childcare. Part of the intervention may therefore not necessarily look radically different from more traditional forms of therapy. However, the desired outcome/endpoint, feeling safer in her own community, may have meaning that is much broader than e.g. anxiety reduction. This implies discussion about the degree to which psychologists could impact more directly at a community or broader societal level.

We also ask trainees to consider to what extent any such shift is possible given the context of access targets for psychological therapies in Scotland. On one hand, the Scottish government's endorsement of the ACE agenda and trauma-informed services may open up opportunities for the profession to promote psychologically coherent interventions that fully take account of the social context. However, how do trainees/qualified staff balance service needs and the demands of their individual job plans with theory based formulations that drive psychological interventions at systems/community/society levels? And if the target of psychological intervention shifts in these ways, how do we then evaluate our impact? What are the important outcomes?

Evaluation and reflection

Our critical psychology workshops, including the one on the PTM Framework, are evaluated through our usual academic quality assurance processes, and appear to be very positively

received across our trainee cohorts. During more informal verbal feedback, trainees particularly valued the practical links that were made and the clinical examples provided. Despite our initial reservations, trainees appreciated having critical psychology teaching in the very first week of teaching, giving them the option to view their training experiences through a particular kind of lens. From the facilitators' perspective, explicitly linking the PTM Framework to the critical psychology teaching material provided strong theory-practice links. The Framework neatly drew together the pertinent literature, distilling theoretical concepts and the available evidence into clear concepts that have both a breadth of vision and a practical utility. Importantly, we argue that the language and conceptual thinking of the PTM Framework embeds the agency of the person seeking help into any formulation. Having taught the broader critical psychology sessions since 2012, the authors also note that key critical psychology concepts have gone from being 'alternative' to 'mainstream', backed by a major DCP publication. This supports the hope that a psychosocial understanding can offer a robust, practical front line approach within wider mental health systems rather than being simply an 'add on'. The workshops, and the PTM Framework specifically, have helped trainees to think about the role of psychology at a service development level as well. This aspect will be extended in future workshop development.

Although the workshops frequently seem to generate more questions than answers, we consider this to be commensurate with the profession's history of training critical consumers and producers of research, capable of developing, evaluating, and refining psychologically informed interventions across different settings. It is from this perspective of scientific curiosity and creativity that we encourage our trainees to engage with the issues highlighted by the PTM Framework, including evaluating its role in promoting formulations that have validity and clinical utility.

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